

Royal College of Psychiatrists

# Psychiatry-East

## The Eastern Division e-Newsletter

*Merry*  
CHRISTMAS AND A HAPPY *New Year*



## Editorial

Hallo, Bonjour, Hola, Ciao...

As we all clutch on to the last legs of being European with Brexit looming large, I hope this newsletter finds you all in the best of spirits and a festive mood.

In this edition at the outset, I talk about the elephant in the room; bullying, followed by an update by the Chair of the Division on the developments in the region. We have moved to a topic based edition and this time the theme is service development and quality improvement. I am grateful to all of you who contributed and am delighted to have received both, a variety and high quality of submissions. This edition makes an interesting read and we have articles from across a breadth of specialities on a range of service developments and initiatives undertaken in the Division, which I am sure will inspire many of us. Setting the scene is Dr Jha who debunks the concept of Quality improvement for us. Dr Ravi enlightens us about setting up of a community forensic service across Essex for patients with an Intellectual Disability. Dr Tomar shares his experience of running a one stop model for patients with Dementia in Hertfordshire. Dr Dakin and her colleagues share their journey of the new Mental Health assessment unit in North Essex. Charlotte Gould and colleagues reflect on a Quality improvement initiative around "zoning" they have introduced in their service in Hertfordshire. Dr El Maraghy updates us on the service development in the region for perinatal psychiatry.

To evoke your competitive spirit I have introduced a token first prize for the best written article in the newsletter. I am delighted to announce the winner this time is Dr Jha. Santa will be visiting you soon! I

have also introduced a new section on Conference Watch in the region which will hopefully help peers get feedback from conferences and events. In this edition we have a report on the Eastern Region Intellectual Disability and Old Age Psychiatry Conference. In addition as a customary we have the feedback on the Eastern Division Conference by Dr Suresh.

The endeavour is to make the newsletter a valuable resource and a platform for all members of the Division, trainees to Consultants. As always, if you are interested in contributing to the next edition of our Newsletter in Summer 2019, we would love to hear from you. Also if there are conferences and events you have attended please do review and feedback. So go on, tap into the JK Rowling inside you!

We would welcome any feedback to help us continue to grow.

Wishing you and your family Joyeux Noel, Fröhliche Weihnachten, Feliz Navidad, Buon Natale...as from next year it will only be Merry Christmas! Have a great 2019!!



### Inside this issue:

Editorial	1
My two pence worth	2
Chair's Column	3
QI for jobbing Psychiatrists	5
Essex Community Offending Behaviour Service	7
Service Innovation - EMDASS one stop clinic in Hertfordshire	9
A New Mental Health Assessment Unit in North Essex...	11
Entering a new Zone? Reflections on implementing a 'traffic light'...	13
Perinatal Services	15
Conference Watch	16
ID East England Conference...	16
Report on Joint DeNDROn...	17
Eastern Division Autumn Conference 2018	18

Dr Indermeet Sawhney, Editor, Psychiatry East



## My two pence worth..

By Dr Indermeet Sawhney

Your sense of humour got rusty or was it an uncharitable remark? Delusional paranoia or snide comments to embarrass you grounded in reality? Persecutory syndrome or being undermined every so often? Special treatment being dished out as an overbearing supervision for you! Feeling left out and excluded in meetings and conversations! Like superman/woman does it seem the responsibilities of your job role have no boundaries? Are you expected to be a psychic and clairvoyant and to anticipate and pre-empt everything at work? Differential treatment being offered to you compared to your peers. A very high threshold of scrutiny and accountability for you as compared to your peers with the same job responsibilities? Are you damned if you do and damned if you don't?

Does the above ring true? The diagnosis is sinister **bullying**.

### Prevalence

A BMA survey revealed that almost 40% of doctors think bullying is a problem at their work place. Over half of the respondents thought that it was difficult to challenge these behaviours, as they came from the top(1). There are concerns that the scale of the problem is greater as bullying is under reported.

### Vulnerable group

The results of the NHS England Staff Survey show that disabled staff, followed by LGBT staff are more likely to experience bullying. BME and female gender are more likely to be on the receiving end of bullying. Take heart in the fact that your strengths at work could well be making the bully insecure and threatened and trigger the bullying behaviour.

The manifestation of this malady can be varied and adversely affects the staff member, patients and organisations. Bullying can lead to increased feelings of burnout in employees(2) Bullying can lead to reduced staff motivation and morale and a decline in work quality. Staff who continue to work while being bullied are more likely to make mistakes and are less productive. A doctor being bullied will be less likely to speak up, report adverse events, will be less effective in team work settings and will also be less likely to ask for help when uncertain on clinical issues, thus impacting on patient safety and care(3). Bullying impacts organisational effectiveness because of increased sickness absence, reduced productivity, employee turnover, litigation costs and organisational reputation. It is estimated consequences of bullying and harassment have financial implications and cost NHS England £2.2 billion a year(4).

The 'mantra' to manage this condition is: "Keep calm and stand up". You owe this to yourself!

Talk to someone and you will discover the bullying behaviour of the individual is an open secret. The attitude of acceptance of 'this is just how Dr Jo Blogs is' needs to be done away with for a start. Bullying and inappropriate behaviour needs to be called out as soon as it happens and should be dealt with quite clearly, soon and proximate to the incident(5). In the Mid Staffordshire report, Robert Francis recommended that a culture of fear and compliance needs to be abandoned, and that efforts should instead focus on fostering an environment of 'openness, honesty and transparency'(6). He also opined that the myth of some doctors being indispensable should not protect bullying doctors from punishment(7). The BMA's advice on reporting bullying emphasises that it is the responsibility of the employer and the employer's human resources team to provide a policy on bullying to all employees, and that any concerns raised should be dealt with seriously and efficiently(1).

### Other Prophylactic measures

Staff training needs to be increased to improve staff awareness of bullying and equip them to challenge it. Staff need to feel empowered so that they feel enabled to speak up. Employers need to create a constructive and inclusive workplace culture and value diversity, with a thrust on collective leadership. It is imperative that senior Consultants lead by example and model good behaviour. Organisations need to undertake staff surveys and feedback to identify bullying and capture how they feel about the processes to deal with the issue to further improve on strategies to tackle this problem(1).

The poem of the Nobel Laureate Tagore, comes to mind "Where the mind is without fear and the head is held high.." Let's aspire to create this world!

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## Chair's Column

By Dr Abdul Raouf

Winter is still mild...we are still waiting to hear the final word on Brexit... But, certain things in life are still predictable.

As we prepare to welcome 2019 after a well-deserved festive break with friends and families, we reflect on the past year looking forward to new challenges and opportunities we expect in the New Year. Despite Brexit dominating the air waves, NHS and mental health care remain high on the political agenda.

One of the most humbling and inspiring aspect of being involved in College activities for me as your Chair is the privilege of meeting and working with some wonderful people – patients, carers, members and trainees – who give up their personal and family time voluntarily to advance College objectives.

I am particularly proud of the contribution Mrs Kate King, our Service User Representative and Executive Committee member has made to the recently published [MHAct Review](#), being part of the Working Group. You might have noticed Kate was busy giving interviews to [national print and broadcast media](#)

The Independent Review chaired by Sir Simon Wessely has made 150 recommendations. The government has already accepted two of the recommendations and we have opportunity to comment on others. The College has published its [response to the Review](#). Please try to read the report as relevant to your area of practice and share your thoughts with the College with specific examples from front line. Real life examples and stories are very useful and powerful in discussions, our College would be having with the government and law makers.

2018 was a very successful year for the Eastern Division in many ways; I am sure you would agree our Autumn Conference in Cambridge was the highlight with record participation from members, trainees and medical students. I enjoyed every moment of it. Congratulations all the prize winners in poster and medical student essay competition (see overleaf for list).

Our Division's activities to promote psychiatry and support our trainees in their career progression are well appreciated by the College. The close working relationship we maintain with School of Psychiatry (HEEoE - Health Education East of England) has helped us to develop and implement useful joint initiatives with our members and trainees. Other Divisions are trying to develop similar arrangements.

Dr Chris O'Loughlin, our ETC representative in our Executive Committee and Head of School of Psychiatry has won the Psychiatric Trainer of the Year award at the [RCPsych Awards 2018](#). Konrad Wagstyl, from Cambridge was the other winner from our region. He won the Medical Student of the year award. Congratulations to Chris and Konrad!

Our [StartWell](#) event was a huge success this year. I had the opportunity to meet many of our Senior Trainees and newly appointed consultant colleagues on the day who had many suggestions on how to improve the initiative and to maintain a network of new consultants in the region. Please let Dr Abu Abraham, who leads on StartWell have your ideas and suggestions if any ([email: a.abraham4@nhs.net](mailto:a.abraham4@nhs.net))

Our Section 12 Induction course continue to receive great feedback and the next course is in April 2019. More information will be available soon for this course.

During 2018 we have managed to increase the number of College examiners and [College Assessors for AACs](#) from the region. If you are interested in these or any other roles please contact me for further information.

I am also pleased to note that number of Fellowships awarded by the College to members in our region is also going up. As you know, [Fellowship of the College](#) is awarded as a mark of distinction and recognition of contributions to psychiatry.

Some of you might have noticed the College has launched a new website. I have inserted multiple hyperlinks in this piece to make it easy for you to get further information. Please let me know if you have any feedback on the new website which I will pass on to the College website team.

While we are talking about technology, the Eastern Division also has entered social media world, though slightly late! Our new official twitter handle is [@rcpsychEastern](#). Within weeks of its launch we already had 77 followers!

Finally, I know many of us are experiencing varying degrees of pressure/stress at work due to increasing work load, changes in services, lack of resources and well recognised challenges in recruitment. As the College continues to work centrally to inform and influence relevant policies and government decisions, at local level College Divisions should provide a forum for

## Chair's Column

By Dr Abdul Raof

networking and mutual support for our members. If you have any suggestions on how we can improve College activities in the region, please let me know.

Thanks to all of you for your help and support in College activities throughout 2018.

Wishing you all a joyous Christmas and Happy New Year!



*Dr Abdul Raof. Chair, Eastern Division  
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### Eastern Division 2018 New Fellows

*Dr Iman Mustafa Elhag (Leigh-on-Sea)  
Dr Millind Ramkirshna Karale (Luton)  
Dr Gbolahan Olabode Otun (Chelmsford)*

### Poster Prize Awards - Autumn Conference 2018

#### Medical Student Category

*1st Prize - Rachel Ward  
2nd Prize - Ben McCartney  
3rd Prize - Anna McKeever, Alvar Paris, John O'Brien,  
Li Su*

#### Foundation Year Doctor Category

*1st Prize - Dr Chevanthy Gnanalingham  
2nd Prize - Dr Harry Mitchell, Dr Rahul Tomar  
3rd Prize - Dr Ali Moonan, Dr Adeela Abassi.  
Dr Hannan Sheftel, Dr Saraj McNally*

#### General Category

*1st Prize - Dr Lauren Redding, Dr Michael Walker  
2nd Prize - Dr Christina McGrady, Dr Charles Le Grice,  
Dr William Burbridge-James  
3rd Prize - Dr Alan Kershaw, Dr Chris Robuck,  
Dr Steven Willis, Dr V Menon*

#### Multi Disciplinary Category

*1st Prize - Olga Bardsley, Hannah Brookes, Lauren  
Hackett, Hildah Jiah, Zohra Taousi  
2nd Prize - Tracey Holland  
3rd Prize - Vanessa Cotter, Stephanie Minns*

### Autumn Medical Student Essay Prize 2018

*Winner - Jessica Henry*

## Quality Improvement for the jobbing Psychiatrist: A Personal Journey

By Dr Tulika Jha

Gone are the days where career paths for Consultants diverged towards neat destinations like education, management, research and leadership. Currently, these distinctions are not so clear. All of these skills are required if we are to truly survive in the NHS of today and this is how I define and understand quality improvement. I can no longer afford to complete my clinical work and reserve quality improvement to a special interest session.

I have learnt about QI through personal experience and would highly recommend it. I started with what grabbed my interest. I analyzed the care pathway of patients with eating disorders and co-morbid personality disorder in my team and presented this as a poster at the Eating Disorders annual conference. Although the work was much appreciated, I was unable to follow through some of the main actions that I had recommended. I reflected about where the barriers were.

The first stumbling block was that I had conducted the work alone with the help of my trainee to collect data. Although I had identified a quality issue (patients with this comorbidity received varied care from 2 or 3 different services with little joint working), I had not considered the wider context (restructuring of community services in my organisation which included the disbanding of the personality disorder service). I had overlooked the most important task of engaging both the teams involved. As I was working in the community eating disorder service, engaging this team was easier than the community mental health team but in this dynamic I was creating a split between the teams that were to carry out the recommendation from this work. There was no shared understanding of the issue from the very beginning. This meant that there was no joint creation of aims and measures and the project fell short at the first PDSA cycle.

### Is QI a complex process?(1)

The answer for me is a resounding “yes” both for it being complex and a process. But complexity doesn’t mean doom and gloom. It gives birth to creativity, bringing ideas, people and change together. Moreover, in a system as complex as our NHS, simple tools without the understanding of the structure, process and culture will always give unsatisfactory outcomes. However, a good methodology will take the complexity and hone down to the specifics of the issue making the task as simple as possible to understand and action through a range of both scientific methodology and sharing the vision of

change to engage and empower people. It does this in real time and continuously.

QI is as much an applied science (2) as it is an art. The art of it lies in leadership, engaging people, building a culture of psychological safety where new ideas can be safely tested. It lies in the understanding that our NHS is a living system. The success of any change depends upon winning both the minds and hearts of people who will carry the change. This is why initiatives that promote equality, diversity and inclusion are central to improving the quality of care delivery. This does not just include staff (Workforce Race Equality Standards(3), Gender pay gap(4), bullying and harassment reduction initiatives) but also requires true and meaningful involvement of our service users and their friends and families. The 3 basic things we need for any QI initiative are: people, place and time which makes recruitment and retention plans pivotal to care quality.

Another important and rapidly developing concept is one of ‘systems thinking’(5) and is an important part of quality improvement in that it brings the focus back to local communities, local knowledge and local need. This underlies the emergence of integrated care systems and sustainable transformation plans.

The applied science forming the basis of QI provides reliability and validity. This is similar to research hypothesis in that a hypothesis is developed from theoretical knowledge, data is collected using correct methodology and analyzed and presented in a form that provides most accuracy (statistical process control methods that account for variation versus aggregated data) and the results are interpreted with clinical and contextual knowledge to make SMART (specific, measurable, achievable, relevant and timely) recommendations and action plans.

So, what I am trying to say is...

You don’t need to be in positions of authority, have state of the art software, have lengthy training to engage in quality improvement.

Here is a non-exhaustive list that has helped me:

- To understand that QI is a continuous and simultaneous process (a bit like living and breathing), one does it as one goes along instead of waiting for the right time, training or role.

## Quality Improvement for the jobbing Psychiatrist: A Personal Journey

By Dr Tulika Jha

- To appreciate that a mixture of skills are required - whether it is leadership, education, research or management.
- To be curious about people, their motivations and the culture within the system that you are wishing to change so that people can be empowered and enabled to create capability and capacity for change.
- To align organizational values and vision with improvement priorities in a clear and structured way.
- To embed the change sustainably, seek to develop an organizational infrastructure to support the change at scale.

I hope I have moved a step closer to de-mystifying QI and encouraged you to start talking about it with your teams and then jumping right in! It does not need to be perfect and mistakes are how we learn in QI and in life.



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3. Workforce Race Equality Standard: NHS England
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5. Working in Systems: process and systems thinking 2017 NHS England

# Essex Community Offending Behaviour Service

By Dr Ambiga Ravi and Trudine McManus

## Introduction

In accordance with the NHS England Transforming Care Model Service Specifications (January 2017)<sup>(1)</sup>, Essex Community Offending-Behaviour Service (ECOS) has been commissioned to meet the needs of adults across Essex. ECOS provide specialist community-based support to meet the needs of adults (aged 18 and over) with a confirmed diagnosis of learning disability and or with a confirmed diagnosis of autism; and who either exhibit offending behaviour\*, are considered to be at significant risk of offending and present a risk of serious harm to the public.

\*Nb. In relation to what constitutes 'offending behaviour' it is useful to consider Johnston (2005) for clarity - 'to commit an offence, one must have the capacity to know that the act is unlawful and being committed deliberately in that knowledge - that is, with intent'.

The scope of Essex Community Offending-Behaviour Service (ECOS) includes both service users currently detained in secure inpatient services and who require specialist support through their transition and discharge, as well as service users living in the community.

## Service Specification

ECOS shares the core aims of community-based forensic support set out in Transforming Care agenda, with the following functions of support; Forensic risk assessment and management of risk in the community to ensure public safety and the safety of the individual and delivery of offence-specific therapeutic interventions (e.g. sexual/violent offences). ECOS provides case management of the most complex cases; provide support, training and consultancy to other teams, organisations and care providers to ensure that the needs of this population are being met, provide in-reach support to achieve smooth and effective discharge from secure inpatient settings to the community.

ECOS has established a referral process and provided clarification to stakeholders. Each individual referred to ECOS has a specialist risk assessment (either the HCR20 for violence risk or the RSVP for sexual violence risk). The risk management strategies generated from this provide a framework for working with service providers and for the development of positive risk taking programmes.

ECOS is a multidisciplinary team that comprises of a

Highly Specialist Clinical and Forensic Psychologist (Clinical Lead), one Community Nurse Practitioner, one Community Learning Disability Nurse, a Specialist Occupational Therapist, a Psychology Assistant and a part time Consultant Forensic Psychiatrist and a part time Speech and Language Therapist.

## Integration with stakeholders

ECOS sees itself as a community based forensic team and its integration to other community teams and care providers is paramount in achieving its full potential to support its case load. It was therefore essential for ECOS to be well integrated with these teams to ensure a more cohesive service delivery and to promote clarity in inter-team communication. To this end, members of ECOS have engaged, supported and established links with South Essex (EPUT) and North Essex (HPFT) LD community teams. This continued liaison and integration is achieved by attending the respective team's referral meetings and providing consultation and support on a number of complex cases under the care of the community teams. ECOS also provided training on HCR20 to senior members of the community teams.

In addition to promoting ECOS's role with the relevant health professionals across Essex, the team has also developed working relationships with the Complex Behaviour Team (CBT) from Essex County Council and their colleagues in the Behaviour Assessment Team (BAT). This was in recognition that a number of the cases in the initial cohort referred by the Commissioners are on the caseload of the CBT. Again it is essential to ensure a cohesive overall service delivery, to clarify roles and minimise any chance of duplication. Steps taken to develop working relationships include inviting CBT to attend ECOS's weekly team meeting, attending CBT's team meeting, joint visits to service providers, joint visits to secure inpatient services, attending triage meeting to discuss a potential new referral, attending a service development event for both teams and opening up HCR20 training to the CBT and BAT.

ECOS has additionally made links with Phoenix Futures Full Circle, the Liaison and Diversion Team within EPUT and Essex Police's Management of Sexual Offenders and Violent Offenders (MOSOVO) team in Colchester. ECOS has established, and continues to develop, positive working relationships with care providers. This has included contributing to the identification of placement profiles for service users preparing for

# Essex Community Offending Behaviour Service

By Dr Ambiga Ravi and Trudine McManus

discharge, consultation on the development of care plans and risk management strategies, staff training in relation to the individual service users and the development and monitoring of positive risk taking programmes. ECOS has additionally been part of the tender evaluation team for a new service for a number of high profile service users preparing for discharge and will continue to work with the new providers on service development.

## Team Values

It is recognised that the fundamental aim of the team is to promote the assessment and management of risk through offence-specific interventions, case management and intervention, consultancy and advice, training and support and in-reach in preparing for transition and discharge. It is the team's view that this might be more effectively achieved by adopting a holistic strengths-based approach(2). Quite a number of the team's referrals have a long history of challenging services, multiple placement breakdowns and multiple hospital admissions. It is likely that they will have experienced a series of problem-focused interventions and may have felt 'demonised', not least because of the level of anxiety generated around them. The team feels that adopting a strengths-based approach is likely to be more conducive to engaging such individuals, who may have been resistant to engaging. With this in mind, together with the need to identify an outcome measure (4) for quality of life(6), the team has included Life Star (Triangle Consulting)(7) as an outcome measure for this service. It measures change in five steps: It is not working, it is difficult but I am getting help, It is OK, It is more how I like it, It is right for me. We are currently in the process of reviewing the Life Star scores after six months to look at the trends of the score and collating data in this context.

## Way Forward

We were started as a pilot service with a maximum case load capacity of 20 patients in March 2017 and became regularised in October 2018. Over the past many months we have built up our case load to 45 patients. Our challenges remains in discharging our patients back to the community teams for maintenance support in the community. It is also a challenge for our team to be truly and fully incorporated within the community teams. Achieving a seamless flow of patients through the Essex Community Offender Services would be considered a great success to this model of care.



*Dr Ambiga Ravi, Consultant Forensic Psychiatrist  
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## Service Innovation - EMDASS one stop clinic in Hertfordshire

By Dr Rahul Tomar

The National Dementia Strategy (NDS) in 2009 estimated that only 42% of the people with dementia ever received a diagnosis of dementia. It set a target of diagnosing 67% of the estimated number of people with dementia, measured by dementia diagnoses per PCT per year (as reflected in GP recording of the diagnosis on their QOF register)(1).

Hertfordshire Dementia Strategy 2015-19, set a target to assess, diagnose and start treatment within 12 weeks of referral. In Hertfordshire the Early Memory Diagnosis and Support Service (EMDASS) had been in operation since 2011, however meeting the 12 week diagnostic target had been challenging with only 40 - 50% of patients receiving their diagnosis within 12 weeks.

### EMDASS one stop model

The remodelling of the EMDASS pathway was undertaken in a series of process mapping with EMDASS team managers, Consultants, Nurses, Occupational Therapists and the Psychologist. Process mapping allowed the teams to look at the existing pathway in detail, examining the problems and delay areas. The outcome of the exercises was the proposal to revise the existing pathway to deliver a "One Stop" model.

In the One Stop pathway, the patient is offered an appointment at 6 weeks following referral or shortly after (not longer than 9 weeks). Patients are assessed and diagnosed in a single appointment following assessment by a specialist dementia nurse and a Consultant Psychiatrist.

The pilot was commenced in one of the four quadrants of Hertfordshire initially and appointments at the One Stop clinics started from October 2017, seven weeks following the commencement of Triage. Each of the three consultants in the quadrant, did 2 one stop clinics per week. In each clinic, two new patients were seen. During the 13 weeks of pilot, 127 service users were seen.

For the very small number of patients who were unable to access a clinic, usually because of other existing health conditions, the specialist dementia nurse will see them in their own home. The nurse will then provide a non-specific dementia diagnosis and report back their

assessment to the multidisciplinary team to confirm the diagnosis.

Each assessment usually lasts two hours and includes detailed history taking from patient and carer. Addenbrooke Cognitive Examination III is the cognitive assessment undertaken and Bristol Activities of daily living scale is completed followed by disclosure of diagnosis. Where appropriate, patient is commenced on anti-dementia medication. Advice on driving and immediate post diagnostic support is given. Latter include signposting & carers information provided in all cases where a dementia diagnosis is made. Those diagnosed with Mild Cognitive Impairment (MCI) were offered an option of attending MCI group.

In every case, a detailed letter to GP and patient is sent informing the diagnosis, medication prescribed (or not), follow up arrangement in titration clinic for those prescribed medication & information for patient and carer to inform DVLA of the diagnosis. Every patient, whether they are on medication or not will later receive a home visit from EMDASS to give a more detailed post diagnostic support that will include post diagnostic care plan, information and advanced care planning.

The advantage of this model is that joint assessment by consultant and specialist nurse improves quality by reducing the time from referral to diagnosis by several weeks. Nurses are more confident of assessing complex patients which previously were rebooked in the consultant clinic. As there are two professionals involved, clinics are less likely to be cancelled. It also enables consultants to see titration clinic patient when specialist nurse are doing cognitive testing thereby improving the efficiency of the clinics significantly. Average of 2 new and 2 titration patients are seen in an EMDASS one stop clinic.

The main barrier in smooth running of the EMDASS one stop clinic is availability of CT scans. The average waiting time from referral for a scan and report can be 6-8 weeks. As a result some patients do not have scan results available at the time of assessment. We are working with commissioner to resolve it.

The one stop model was gradually rolled out in all quadrants of Hertfordshire. Weekly hot spot reports are produced to monitor the performance. The last hot spot report from 14th September showed 80.94% of referrals were seen in less than 12 weeks. This was a significant

## Service Innovation - EMDASS one stop clinic in Hertfordshire

By Dr Rahul Tomar

improvement over 40-50% we were achieving earlier.

Apart from these objective measures, feedback from patients, carers and staff has been very positive all of which make this model a success.

### References

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# A New Mental Health Assessment Unit in North Essex

By Dr Catherine Dakin, Dr Ratna Ghosh, Dr Ahmed Shoka, Mr Robert Rooke

## Background

The Peter Bruff Mental Health Assessment Unit (PBU), situated in Colchester, in the North of the Essex Partnership University Trust (EPUT), opened in July 2018, aiming to change the way in which patients flow within the system, to reduce the length of inpatient admissions, and to assess and care for patients closer to home. It is a mixed sex, dedicated inpatient facility, providing a short (3-5 days), intensive period of multidisciplinary assessment for adults presenting in psychiatric crisis.

'Gatekeeping' assessments are usually undertaken by Home First (previously known as Home Treatment Team), who assess and manage patients in the community, to avoid preventable inpatient admissions. However, if all community options have been exhausted, and if the patient is deemed to have a capacity to consent to an informal admission, they will be referred to this new assessment unit. Those under a section of the Mental Health Act, under normal circumstances are not admitted to PBU.

In addition to their role in assessment prior to admission, Home First will, where appropriate, facilitate discharge of patients from this unit, providing them with an intensive level of support, bridging the gap between inpatient and community services.

While length of stay is aimed to be 3-5 days, patients may stay for a maximum of seven days if it is thought that their crisis management and safe discharge cannot be achieved within this timeframe. If it is found that a longer period of assessment and treatment is required, the patient will be transferred to an acute inpatient treatment ward as soon as practicable. Furthermore, if it is deemed necessary to place a patient under a section of the Mental Health Act during their admission to PBU, they will be similarly transferred to a treatment ward.

## Implementation of innovation since opening:

To uphold a truly multidisciplinary approach to patient care, daily MDT meetings take place at 9am, Monday to Friday, with representatives from Home Front, Psychology, Occupational Therapy, and the Nursing Team, as well as Ward Manager, Discharge Coordinator,

and full medical team in attendance. Consultant-led reviews take place Monday to Saturday, allowing the implementation of individualised care pathways and discharge plans without delay. Saturdays provide a greater opportunity for family to attend reviews. Home First regularly attend reviews, in order to assess the need and suitability for their support on discharge. Care coordinators are identified or allocated as early as possible, with the option for CPA meetings occurring via conference calling, allowing an integrated approach to patient care to occur in timely manner.

As a Trust, we are now paper-lite. All gatekeeping assessments, information sharing, community and inpatient assessments, referrals, letters and supplementary documents from inpatient and community teams are communicated via the electronic system used in the North of EPUT, called *Paris*. In this way, information can be accessed and recorded as needed by the team and the wider Trust, ensuring that the patient's care, safety and experience is optimised. Improving the standard of integrated physical and mental health is vital, so a full physical systems examination by a doctor is electronically recorded at the time of admission. Blood results are accessed electronically, and similarly added to the system. By ensuring that physical health matters are consistently documented in this way, it is possible to monitor, prevent and treat physical co-morbidities, and communicate such information to all involved in their care (including GPs).

## Evaluation of the service:

Since opening, there have been 354 admissions (over a 19-week period), with approximately 70% being discharged back into the community (with an average length of stay of 5 days), and 30% being transferred to inpatient wards for further treatment. This has been achieved despite not having the full complement of medical and nursing staff identified for efficient functioning of the unit.

Patient and family feedback has generally been very positive. Similarly, feedback from Consultant Psychiatrists, from local treatment wards, have been very encouraging. They have acknowledged the reduction in number of admissions to the treatment wards, allowing

# A New Mental Health Assessment Unit in North Essex

By Dr Catherine Dakin, Dr Ratna Ghosh, Dr Ahmed Shoka, Mr Robert Rooke

them to focus on complex admissions. The number of patients being admitted to 'out of area' beds have fallen sharply.

Initial findings from an in-house cross-sectional audit show that patients are, in the most part, being admitted in line with defined criteria (all community options exhausted, and capacity to consent to informal admission), are receiving an MDT approach to their treatment, and the care pathways to which patients are discharged are appropriate. Whilst there are patients who continue to re-present to services with high frequency, notably those with personality disorders, many now do not. Instead, they can be seen to be engaging with community services, with the initial support of HF, followed by community mental health teams, as appropriate. For those transferred to a treatment ward, it is evident that transfer, in majority cases, was appropriate and useful to the patient.

## The future of PBU:

Over the coming months, it will be possible to collect additional data and further evaluate PBU, and to implement adaptation and change, in order to best suit local service users as well as the wider Trust. Formal feedback from patients and their family or friends is currently being collected, to further inform service improvements. Management of patients with Emotionally Unstable Personality Disorders remains a significant challenge, and finding solutions to minimise unhelpful inpatient admission/discharge cycles is a current priority for community and inpatient teams. However, at this early stage, the Mental Health Assessment Unit can be both objectively and subjectively viewed as a success, with a solid foundation on which we can continue to build and improve the service.

Monthly Admissions to PBU (July-October 2018)

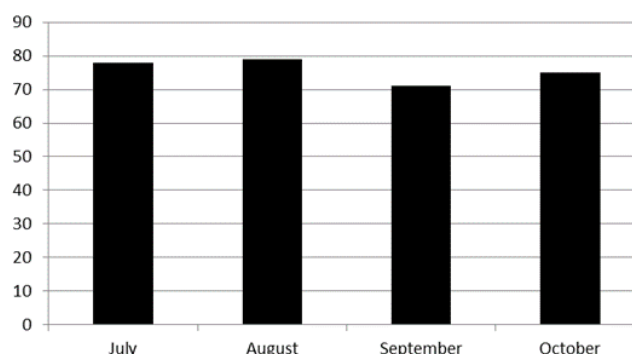


Figure 1: Monthly admissions to PBU in the first 4 months of operation, with an average of 75.75 admissions per month.

Monthly Discharges / Transfers from PBU (July-October 2018)

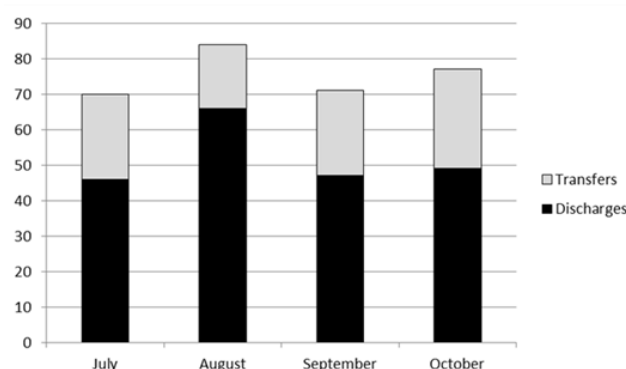


Figure 2: Showing relative proportion of discharges and transfers from PBU in the first 4 months of operation.

Dr Catherine Dakin (FY2), Dr Ratna Ghosh (Consultant Psychiatrist), Dr Ahmed Shoka (Consultant Psychiatrist), Mr Robert Rooke (Ward Manager)  
Essex Partnership University NHS Foundation Trust

# Entering a new Zone? Reflections on implementing a 'traffic light' risk management approach to the Hertfordshire Early Intervention in Psychosis service

By Dr Charlotte Gould, Dr Zohra Taousi and Hildah Jiah

'Zoning' is a dynamic approach to managing clinical casework in order to effectively target resources to deliver care. Research demonstrates that a zoning approach can ensure that clinical knowledge and expertise is co-ordinated to reduce the likelihood of unilateral decisions being made by using a team approach to problem-solving. By using zoning, the team caseload is displayed on a spreadsheet and colour coded using a traffic light system of Red, Amber and Green (RAG). Red is used to signify service users most at risk, Amber signifies those at moderate risk, and Green identifies those who are more stable, although they may still be unwell and requiring intensive input. This article discusses the benefits and challenges of implementing this approach within a specialist mental health team.

Since launching a new countywide Early Intervention in Psychosis service in 2017, PATH (Psychosis: prevention, assessment and treatment in Hertfordshire) has incorporated zoning into practice, as well as adding three additional areas to the RAG model to enhance ease of use. These are forthcoming new assessments, in-patients or clients under acute services, and those ready to be discharged. These additions add more clarity in having an overview of clients moving through the care pathway.

## Benefits of zoning

The zoning protocol is intended to provide a framework to target interventions and EIP team resources, with the aim of supporting service users more intensely and reducing risks. Research has found it to be more user friendly than traditional care programme approaches to risk management<sup>(1)</sup> and it allows for the sharing of responsibility as a team. All service users in the Red and Amber zones receive a more intensive input from key workers than those in the Green zone. Service users may move between zones as their circumstances change and may be moved to a 'higher' zone if there are concerns that they may be relapsing, disengaging from services, stopping, or changing treatments or where there are changes in their level of risk or major social stressors such as homelessness or significant loss of any nature. This allows for reactive management of risk as a client's risk may change rapidly in EIP settings.

Feedback from staff within the PATH service is limited due to the recent application of this model. However, collaborative weekly discussions with the team endeavour to find a solution on how best to respond to a client's particular risks. If a service user is placed into the 'red zone' the policy states that at least two meaningful contacts a week are to take place, with the aim being to monitor their mental state, offer support and evaluate or respond to any further increase in risk. Those in an 'amber' state are seen once a week and those in a 'green' zone perhaps require less input. As a multidisciplinary team with a large caseload and incoming referrals, it can be useful to categorise service users into different 'zones' so we are aware of the level of input they (and their families/partners) require.

The PATH service, and other EIP services are receiving an increasingly large number of referrals, and research recognises that the zoning approach is beneficial to resource allocation<sup>(1)</sup>. Zoning encourages assertive engagement whereby team discussion allows for developing plans to address identified risks, whereas traditional CPA models may not allow for this<sup>(2)</sup>. In this sense the zoning approach places value upon assertive engagement through appropriate and proportionate follow-up and actions by team members.

Another advantage to zoning is it draws attention to clients who have an upcoming discharge or transfer. This highlights service users who have been identified as coming to the end of the first episode psychosis (FEP) care pathway and are moving towards discharge back to either primary care or transfer to another service. Having service users identified in this way gives the team opportunity to concentrate on equipping service users with skills to assist them after their eventual discharge. Discharge can be an anxiety-provoking time for both service users and carers, and therefore work needs to be ongoing for service users in the green zone to ensure a successful discharge back to primary care or transfer to a more appropriate service.

## Challenges of zoning

The process of zoning is fluid and service users can move up and down the zoning board depending on their current mental state and consideration of any risk issues. Due to the unpredictable nature of mental health

# Entering a new Zone? Reflections on implementing a 'traffic light' risk management approach to the Hertfordshire Early Intervention in Psychosis service

By Dr Charlotte Gould, Dr Zohra Taousi and Hildah Jiah

presentations e.g. relapse and difficulties of predicting recovery time, service users do not necessarily need to move from Red to Amber to Green in a linear fashion. Therefore, it is possible that a service user could move from Green to Amber or even Red.

Though the zoning approach acts as an effective risk management tool, and this is of intrinsic usefulness, it may not always identify people who are of low risk but high need. For instance, someone with adequate family support, maintained symptoms and stable housing may present as 'green' on the zoning, yet this client may have unmet need such as support of daily living skills, unemployment and benefits. This distinction between the 'reds' and 'greens' should be continuously questioned, so that teams are able to support low risk but high need clients and ensure they do not deteriorate in their mental health. Potential solutions could be drawing a distinction between need and risk and ensuring the MDT have time to discuss those service users.

EIP services represent a diversity of professionals including consultant psychiatrists to specialist nurses, psychologists, community psychiatric nurses, social workers, occupational therapists and support time and recovery workers. Differing breadths of experience mean there are a wide range of thresholds and perspectives within the team. Care must be taken to safeguard against any potential underestimation of risk as the EIP team regularly deal with 'risky' clients and could have the propensity to become complacent.

## Conclusions

Whilst the zoning approach is still in its infancy within the PATH service, it seems to be a simple yet effective tool to the management of resources to manage risk in EIP service users.

The service could be encouraged to use the tool more collaboratively with service users as a shared decision making tool for service users. In this sense, it could encourage professionals to be more open and reflective when discussing risk with clients. Ultimately, the effectiveness of the zoning process is dependent on both individual and team clinical judgement, and therefore good knowledge of the service user and their social support networks as well as an accurate risk assessment

and risk history are vital components for sound decision-making.

*Dr Charlotte Gould, Associate Practitioner  
Dr Zohra Taousi, Medical Lead and Consultant  
Hidah Jiah, Nurse Consultant  
Hertfordshire Partnership University  
NHS Foundation Trust (HPFT)*

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## Perinatal Services in the Region

By Dr Manal El-Maraghy

Inspired by the “Everyone Business Campaign” and in response to the LSE and King’s Fund report; the “Five year Forwards View” for Mental Health considered Perinatal Mental Health service development a priority. Acknowledging the devastating impact on the society and to save cost of dealing with the implication of unwell mothers’ mental health on the next generation, (total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK); the Government decided to inject £365 million over the period of five years to ensure that by 2020 extra thirty thousand women will be seen for perinatal mental health related concerns.

In East of England, at the time when the report was released, there was no Community Perinatal team. There were only some attempts to offer care for women in the community during the Perinatal period by committed and devoted staff. In Hertfordshire, a consultant psychiatrist, ran single handed a perinatal community clinic. In Essex a small nurse led team, working closely with primary care, existed unrecognised for few years to support midwife, health visitors and GP.

Essex, Hertfordshire and Norfolk trusts put a bid for wave I fund successfully, followed by the rest of the region’s trusts: Suffolk, Bedford and Luton and Cambridgeshire for wave II. Following the success for the Wave I bid, Essex, Hertfordshire and Norfolk set off to build the newly funded teams as per the Royal college guidelines. Staff number and composition for the team was to be based on the Birth rate in the local areas.

Hertfordshire officially launched its service on the 23<sup>rd</sup> of April 2018. Norfolk service followed on the 29<sup>th</sup> September. Essex, building the team at critical time when two trusts were merging into Essex University Partnership trust (previously North Essex and South Essex) took a little longer to get to the official launch on the 12<sup>th</sup> October 2018. Multidisciplinary teams are working closely with obstetricians, midwives and health visitors, alongside the Adult and Adolescent mental health services. East of England Clinical Network steering group was set up to ensure common high standards.

The other trusts now are building up their teams to be able to serve their local women in the very near future. All the new services are expected to comply with the specification set up by the Royal College of Psychiatrist to ensure the receipt of the money. At the latest National Positive Practice in Mental Health Collaborative, the new teams for Essex and for Hertfordshire, each was awarded Certificate for “Highly Commanded Team”.

In term of inpatient Units, there were already two established mother and baby units: Thumbwood in Hertfordshire and Rainbow in Chelmsford. Lately, Norfolk has succeeded to secure fund for a mother and baby unit to be opened in early 2019.

Training is a core component to the newly developed services, and there is a notable activity. A number of trusts in the region ran some local training events. Essex had an oversubscribed event on the 6<sup>th</sup> of July 2018 with a very positive feedback. Cambridgeshire had a training conference on the 5<sup>th</sup> October with also a good feedback. On the wider scale, The Eastern Division of RCPsych hosted for the first time in the spring conference 2018 some perinatal educational sessions, offered by Liz McDonald and Madeleine Miele. NHSE East in conjunction with RCPsych ran two regional free Perinatal events in October 2017 and September 2018, targeting the wider network involved with mothers in the perinatal period; training was aimed at primary care. Keynote speakers were Alain Gregoire Chair of the Maternal Mental Health Alliance, Dr Trudi Seneviratne Chair of the Perinatal faculty, as well as presentation from women with lived experience.

The service development is ongoing and the training of staff remains pivotal to ensure future excellent quality will remain the focus.



*Dr Manal El Maraghy  
Consultant Perinatal And Adult Psychiatry  
Essex Partnership University NHS Foundation Trust*

## 16th East of England Psychiatry of Intellectual Disability Annual Conference Report by Dr Oliver Duprez and Dr Tawakalitu Kehinde

On Friday 8<sup>th</sup> June 2018, The Fielder Centre in Hatfield welcomed delegates for the annual East of England Intellectual Disabilities conference. The themes were diverse covering leadership and quality in challenging times, epilepsy, autistic typologies, ADHD and performance issues in doctors. The conference was well attended and provided thought provoking insights into some of the challenges faced by clinicians in the field of Intellectual Disabilities Psychiatry.

Dr Kamalika Mukherji organised the conference along with Dr Sophie Shardlow, and opened the event with some introductory remarks.

Tom Cahill, Chief Executive of Hertfordshire Partnership NHS Foundation Trust, and HSJ Chief Executive of the Year 2017, gave an inspiring talk on Healthcare Leadership in challenging times. He compared the challenges faced by NHS 70 years ago with the current difficulties. Mr Cahill went through the 5 Year Forward View, and highlighted the need for increased integration, the need to move from variation to standardization, and new organisational forms, including Strategic Transformation Partnerships (STP's), Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP). He commented " If we standardised healthcare systems across the country to the median, we would get better outcomes." Mr Cahill explained why clinical leadership is important to the transformation of NHS. His inaugural address generated a lot of interesting questions and discussions, and will surely be a regular fixture for future conferences.



Dr Regi Alexander then introduced the concept of autistic typologies. He started by going over the core features and co-morbidities of autism, and used a constellation of stars as a powerful metaphor to describe the core features of impaired communication, social impairment and restricted repetitive behaviours and interests and the three brightest central stars, with other surrounding stars (co-morbidities) such as OCD symptoms, tics, catatonic symptoms, ADHD, and epilepsy to name a few. He then outlined some of the current research into the neurobiology of developmental disorders and their associations with psychotic disorders and personality disorders. He then went on to the issues around offending behaviours in people with autism. He emphasised that law breaking rates are similar or less than the general population, but in certain forensic settings, people with autism are over-represented. Finally, he outlined the different typologies for offending behaviour which can influence treatment outcomes. The full text of this research is available at <https://www.emeraldinsight.com/doi/pdfplus/10.1108/AIA-08-2016-0021>

Next Dr Rohit Shankar gave a powerful synopsis of the prevalence, diagnosis and management of epilepsy in people with intellectual disabilities. He has recently worked on the Royal College of Psychiatrists report into the Management of Epilepsy in Adults with Intellectual Disability, which proposes a traffic light system of competencies for psychiatrists in the management of epilepsy.

Dr Bhatika Perera then gave an overview of his work in developing a new diagnostic tool for ADHD in people with intellectual disabilities, the DIVA-ID, based on the DSM-5 diagnostic criteria. He also updated us on the new NICE guidelines for ADHD.

Dr Asif Zia outlined the structures and frameworks involved in investigating psychiatrists when complaints or allegations are made. His talk gave food for thought for the need to balance accountability and fairness for doctors when complaints are made. A healthy debate ensued about some recent high profile cases.

The conference broke into workshops including a new consultants forum chaired by Dr Daniel Dalton, "how to get published" by Dr Howard Ring and "sexuality, ID and the law" by Dr Sanjay Nelson.

*Dr Oliver Duprez and Dr Tawakalitu Kehinde  
Consultant Psychiatrists in Intellectual Disabilities  
Hertfordshire Partnership University NHS Foundation  
Trust*



## Joint DeNDRoN/East of England Old Age Psychiatrists Dr Vanya Johnson and Dr Judy Rubinztein

Our regional meeting this autumn welcomed Dr Claire Hilton.

She began her career as an old age psychiatrist in Withington Hospital, Manchester and has a long-term interest in history, including a PhD in the subject and a number of publications on psychiatric history. She presented the fascinating story of Barbara Robb (1912-1976) who campaigned for better psychiatric care for older people. This sparked a lively discussion about the parallels with some of the current challenges facing old age psychiatry.

A very successful and well attended joint meeting with the usual Eastern Region meeting was held later in the afternoon focusing on research with three presentations:

Dr Judy Rubinsztein (Co lead for DeNDRON in Eastern region) encouraged consultants and STs to consider becoming a principal investigator for a trials and explained how to go about this.

Dr Ajenthan Surendranathan, a neurologist and PhD student spoke about the diagnosis and management of Lewy Body Disease and Prof O' Brien spoke on initial results from the Diamond-Lewy Study on how to improve diagnoses and management of LBD using their toolkit.

Prof Robert Howard spoke about the results of the MADE study; minocycline in Alzheimer's has not been shown to be helpful, the background to the ATILA study on the use of technologies in AD (results due next year, but study already demonstrates that only 50% of technologies recommended are installed). He also spoke about the very positive results of the ATLAS study which shows marked improvements for patients with very late onset schizophrenia like psychosis on amisulpiride compared with controls.

Prof Howard and Prof O' Brien thanked the many member of the Eastern Region who have helped to recruit and support these trials in this region.



*Dr Vanya Johnson, Consultant Psychiatrist  
Norfolk & Suffolk NHS Foundation Trust  
Dr Judy Rubinztein, Consultant Psychiatrist  
Cambridgeshire & Peterborough NHS Foundation Trust*



## Eastern Division Autumn Conference 2018 'The Ageing Brain'

### Conference Report. By Dr Kallur Suresh



*“The popularity of the event was evident from the record number of 101 registered delegates, including a significant number of Foundation Year Doctors and medical students”*

The Eastern Division hosted its most successful conference yet on 29th November 2018 at the Wellcome Genome Campus in Cambridge. The popularity of the conference was evident from the record number of 101 registered delegates including a significant number of foundation year doctors and medical students.

After a welcome address by the Division Chair Dr Abdul Raouf, the psychopharmacology of mood disorders was explored in some detail by Dr Nick Stafford, from the Black Country NHS Foundation Trust. He linked the current state of research into new treatments with clinical practice and reaffirmed the evidence base for existing treatments.

The audience was then captivated by a new research tool called Network Meta-analysis which has the potential to personalise treatments to individual patients based their choices about efficacy and side effects. Dr Andrea Cipriani of Oxford University spoke convincingly about how to use evidence synthesis to make decisions in mental healthcare using the example of antidepressants to treat major depressive disorder.

The keynote speaker was Professor John O'Brien, a Professor of old age psychiatry from Cambridge University who highlighted the importance of a healthy lifestyle in staving off dementia for as long as possible. The pathological changes in the brain start some 20 to 30 years before a clinical diagnosis can be made using current criteria. He looked at various biomarkers in

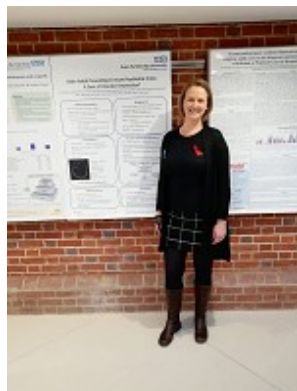
Alzheimer's disease and how they could be used in future to predict the risk of developing the disease in individual patients.

Delegates used break times to network with colleagues from across the eastern region and to view some 40 posters presented on the day. The best posters were selected for oral presentations after lunch and featured four categories - medical students, foundation year doctors, general category and multidisciplinary posters.



## Eastern Division Autumn Conference 2018 'The Ageing Brain' Conference Report. By Dr Kallur Suresh

Each poster was presented for 5 minutes followed by Q and A for a minute. The presentations were rated by judges to decide the winner in each category. The winners were awarded prizes and all presenters got certificates of commendation.



*Delegates with poster displays in the breakout area*

The afternoon academic programme kicked off with a presentation on the ongoing review of the Mental Health Act, 1983 by Dr Adrian James, Registrar of the College. Dr James spoke about the current process for review of the provisions of the Act. The main drivers for the review are the rising rates of detention under the Act, the disproportionate number of people from black and minority ethnic groups detained under the Act and processes that are out of step with a modern mental health care system.

The last academic literature of the day was by Dr Belinda Lennox, Associate Professor of Psychiatry at the University of Oxford. She spoke about the close association between psychosis and certain autoimmune disorders, looking at provision of treatment of psychosis with anti-inflammatory drugs and other immunity-



*Dr Abdul Raof handing out poster prizes*

mediating agents.

This was followed by closing remarks by the Division's Academic Secretary Dr Kallur Suresh and feedback from delegates about the conference. Initial analysis of the feedback shows that the sold-out conference was rated excellent or good in most categories.

Next year's spring conference will be held at the same venue of Wellcome Genome Campus on Thursday, 6th June 2019. Look out for publicity on Twitter and by email and of course on the homepage of the Eastern Division website.

*Dr Kallur Suresh, Academic Secretary, Eastern Division*

*Please follow the official twitter handle of the Eastern Division @rcpsychEastern for latest updates.*

***Dates for your diary***

***Spring Conference:  
Thursday 6th June 2019***

***Autumn Conference:  
Friday 22nd November 2019***

Royal College of Psychiatrists

**Thursday 6th June 2019**  
**Eastern Division Spring Conference**  
**'The Inflamed Mind'**  
**Wellcome Genome Campus, Cambridge**



**FREE Entry for Foundation Year and Medical Students through 'Enhancing Foundation Experience in Psychiatry' initiative of HEEoE School of Psychiatry**



**Lectures on various topics including a keynote presentation, poster exhibitions, prizes and networking sessions**

**6 CPD points**  
**(subject to peer group approval)**

**For further information and to register please visit: <http://bit.ly/2c4B0Ue>  
or contact: [moinul.mannan@rcpsych.ac.uk](mailto:moinul.mannan@rcpsych.ac.uk) Tel: 0203 701 2590**

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Eastern Division is made up of members from Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

We'd like to thank all members for their contributions towards Eastern Division activities throughout the year.

## Eastern Division Medical Student Essay Prize

The Eastern Division has established this prize in order to raise the profile of the Division and to encourage medical students to pursue further study and professional training in Psychiatry.

**Prize:** £200

**Eligibility:** All medical students training in Medical Schools located within the Eastern Division.

**Where Presented:** Eastern Division Spring Conference, 6th June 2019 at the Wellcome Genome Campus, Cambridge

### Regulations:

1. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of psychiatry. The essay should be illustrated by a clinical example from medical or psychiatric practice relevant to mental health and should discuss how the student's training and awareness has been influenced as a result. The essay should demonstrate an understanding of the Mental Health issues pertinent to the clinical problem and should include a discussion of the effects and consequences of the condition for the individual, their family and the wider healthcare system.
2. The essay should be supported by a review of relevant literature and should be the candidate's own work.
3. The Eastern Division Executive Committee will appoint three examiners to judge the entries. Criteria for judging merit will include: clarity of expression, understanding of the literature and evidence, cogency of argument and the overall ability to convey enthusiasm and originality. The Division reserves the right not to award the prize if no entry reaching the agreed minimum standard is received.

**Closing date: Friday 10h May 2019**

Submissions should be made to:

Moinul Mannan

Eastern Division Coordinator

[moinul.mannan@rcpsych.ac.uk](mailto:moinul.mannan@rcpsych.ac.uk)

### Deadline for next edition

Submit your articles for summer 2019 edition by 24th May 2019 to [psychiatry.east@rcpsych.ac.uk](mailto:psychiatry.east@rcpsych.ac.uk)

### Royal College of Psychiatrists - Eastern Division E-Newsletter

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**Review Board:** Eastern Division Executive Committee, Royal College of Psychiatrists

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